



16716

Medical History and Consent to Receive Novel H1N1 Influenza Vaccine

PLEASE PRINT CLEARLY

Health Insurance? ☐ Medicare ☐ Medical Assistance ☐ Private ☐ No Health Insurance
(BadgerCare, Medicaid, Etc.)

Name of Insurance _____ Insurance#/ForwardCard#: _____

Part I. Personal Information for Person to Receive Vaccine

Last Name

First Name

M.I.

Street Address

Apt/Unit Number

City

State

Zip code

Primary Phone

Date of Birth (MM/DD/YYYY)

 / /
Gender: Male
Check One
☐

Female

☐
Age _____ in (check one) ☐ years ☐ months

Race: You may mark (X) more than one:

- ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American
☐ Native Hawaiian/Other Pacific Islander ☐ White

Ethnicity: You may mark (X) only one:

- ☐ Hispanic or Latino/a
☐ Not Hispanic or Latino/a

For people younger than 18 years of age:

Name of Parent or Guardian

Last Name

First Name

M.I.

Mother's Maiden Name

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Screening

Clinic Location / Site Code: Eligible for vaccination today: ☐ Yes ☐ NoVaccines eligible to receive: ☐ Sanofi Pasteur ☐ Novartis ☐ Medimmune ☐ GSK ☐ CSLScreener's Signature Date:

Administration

Manufacturer:

☐ Sanofi Pasteur ☐ Novartis ☐ Medimmune ☐ GSK ☐ CSL

Dose: ☐ .2 ml(nasal)

☐ .25 ml

☐ .5 ml

Site: ☐ NASAL

☐ RD ☐ LD ☐ RT ☐ LT

Lot # (Place sticker here)

Administered by:

Date: / /

Name of Person Receiving Vaccine _____

(Last, First, Middle Initial)

Age of Person Receiving Vaccine: _____

Part II. Medical Information: Mark (X) "Yes" or "No" for questions 1-14**Is / Does the person receiving the vaccine today:**

1. Sick / running a fever?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Have a serious allergy to foods, medications, ointments, latex, eggs, gelatin, Thimerosal (mercury-containing product) or an other substance?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Have a history of seizures, convulsions, epilepsy, Guillain-Barre or any other nervous system or brain problems?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Have a history of serious problems or reactions (including neurological symptoms) with previous immunizations?	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Have a bleeding disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. Have asthma, or had one or more episodes of wheezing in the last year?	<input type="checkbox"/> Yes <input type="checkbox"/> No
7. Have long term health problems such as heart, lung, kidney or liver disease, or metabolic diseases such as diabetes?	<input type="checkbox"/> Yes <input type="checkbox"/> No
8. Have a weak immune system (including HIV, AIDS, cancer, kidney disease, leukemia, or medications such as steroids)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
9. Have close contact with anyone with a severely weakened immune system that requires a protective environment (for example, anyone with a recent bone marrow transplant)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
10. Pregnant?	<input type="checkbox"/> Yes <input type="checkbox"/> No
11. A child or adolescent on long term aspirin therapy?	<input type="checkbox"/> Yes <input type="checkbox"/> No
12. Received any other vaccines within the last 28 days?	<input type="checkbox"/> Yes <input type="checkbox"/> No
13. Currently taking antiviral medications?	<input type="checkbox"/> Yes <input type="checkbox"/> No
14. Have a serious blood disorder (such as sickle cell)?	<input type="checkbox"/> Yes <input type="checkbox"/> No

FOR OFFICIAL USE ONLY**Education: Medical Information Comments**

Part IV. Consent

I have been given a copy and have read about INFLUENZA and the INFLUENZA VACCINE. I believe I understand the benefits and risks of the vaccine. I have been instructed about reasons a person should not get this vaccine, and I (or the person named above, for whom I am authorized to make this request) am not experiencing any condition that would be a reason to not get the requested vaccine. In accordance with Wisconsin State Statute 252.04 and Chapter HFS 144, I understand that all immunization-related information may be shared with Milwaukee Public Schools and the State of Wisconsin. I consent to entry of client's vaccination records into the Wisconsin Immunization Registry. I agree to allow immunization information to be released to our family physician, any medical referral service, and/or insurance companies. My signature below also permits the City of Milwaukee Health Department (MHD) to bill Medicaid (Title 19) or Medicare for all applicable immunization services. I will not be asked to pay for any services provided by the MHD related to this vaccination, and I have been offered a copy of the MHD Notice of Privacy Practices.

Patient/Legal Guardian Signature _____

Date _____